IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0352

December 18, 2008

Chad Mangum
Access Home Care
190 West Burnside Avenue, Suite E
Chubbuck, Idaho 83202

RE: Access Home Care, provider #137110

Dear Mr. Mangum:

Based on the Medicare/Licensure survey completed at Access Home Care on December 3, 2008, by our staff, we have determined that Access Home Care is out of compliance with the Medicare Home Health Condition of Participation on Organization, Services & Administration (42 CFR 484.14) and Acceptance of Patients, POC, Med Super (42 CFR 484.18). To participate as a provider of services in the Medicare program, a Home Health Agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limits the capacity of Access Home Care to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **January 16, 2009. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than January 8, 2009.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.07.003, Access Home Care is being issued a Provisional Home Health license. The license is enclosed and is effective December 3, 2008, through April 3, 2008. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.07.003.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by January 15, 2009. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
P.O. Box 83720
Boise, ID 83720-0036
phone: (208)364-1804
fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

Access
...feel the difference
190 W. Burnside Ste. E
Chubbuck, Idaho 83202
Tel. (208) 637-2273 Fax (208) 637-8867
www.accesshomecareandhospice.com

January 6, 2009

Division of Medicaid -- DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

Attention: Sylvia Creswell, Co-Supervisor

Dear Ms. Creswell,

On December 3, 2008, your staff completed a Medicare/Licensure survey at our office in Chubbuck, Idaho. Our office received the official Statement of Deficiencies on December 22, 2008. In response to the Statement of Deficiencies, we have prepared and enclosed a Plan of Correction.

We were grateful to have Gary Guiles and Patrick Hendrickson as our surveyors. Both were professional, informative, and courteous.

If there are any questions regarding the Plan of Correction, please don't hesitate to call me at (208) 637-2273.

Sincerely,

Chad Mangum BSN, RN
Clinical Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137110	A. BUILDING _____ B. WING _____	12/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HOME CARE, LLC	190 WEST BURNSIDE AVENUE, SUITE E CHUBBUCK, ID 83202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your home health agency. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Acronyms used in this report include: CVA = cerebrovascular accident (stroke) HHA = Home Health Aide NSA = Negotiated Service Agreement OT = Occupational Therapy PA = Physician Assistant POC = Plan of Care PT = Physical Therapy RCF = Residential Care Facility SN = Skilled Nursing SOC = Start of Care SW = Social Worker	G 000		
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION This CONDITION is not met as evidenced by: Based on staff interview and review of patients' clinical records and agency policies, it was determined the governing body failed to ensure systems had been developed and implemented to provide basic care and services to patients and to coordinate care. The findings include: 1. Refer to G133 as it relates to the failure of the agency to ensure the administrator provided sufficient organization and direction to agency staff to ensure basic services and processes	G 122	G122- The governing body of Access Home Care has proper systems in place as of this day January 6, 2009 to ensure all basic care and services are met for the patient. This will be evidenced by the following plan of corrections that proceed in this document. Governing body will be updated on the compliance of the following plan of corrections on a quarterly basis with quality assurance meeting and also as needed or requested by the governing body.	1/6/2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brett Cogen MPA, NHA	Director	1/6/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 122	Continued From page 1 would be defined and provided. 2. Refer to G143 as it relates to the failure of the agency to ensure care was effectively coordinated with outside entities that also provided care to agency patients. 3. Refer to G158 as it relates to the failure of the agency to ensure POCs were developed for private pay and other patients. 4. Refer to G185 as it relates to the failure of the agency to ensure OT services were provided as ordered. 5. Refer to G334 as it relates to the failure of the agency to ensure comprehensive assessments were completed in a timely manner and consistent with patient's needs. The cumulative effect of these negative systemic agency practices resulted in the agency's inability to provide consistent services to patients.	G 122		
G 133	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to ensure the administrator provided sufficient organization and direction to agency staff to ensure basic services and	G 133	G133- The administrator will ensure that all patients regarding payor source will be admitted with Medicare standards, including a comprehensive assessment and development of a plan of care according to Agency's Policy and Procedure #2008. All admitting staff have been inserviced and will be compliant January 6, 2009. (attachment A, Agency's Policy and Procedure #2008 Assessment/Plan of Care). This will be	1/6/2009

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G 133	Continued From page 2 processes would be defined and provided. The agency, through the administrator, failed to ensure that systems were in place to ensure patients were comprehensively assessed, that systems were in place to ensure patients had POCs to direct staff in the provision of care, that systems were in place to ensure care was coordinated with other providers who furnished care to agency patients, and that systems were in place to ensure occupational therapy services were available to all patients. These omissions affected the care of 8 of 15 patients (#1, #3, #4, #5, #7, #8, #10, and #14) whose care was reviewed. The findings include: 1. The administrator had not ensured a system had been developed and implemented to provide comprehensive assessments to private pay patients. Refer to G334 as it relates to the lack of assessments for private pay and other patients. 2. The administrator had not ensured a system had been developed and implemented to develop plans to direct the care provided to patients. Refer to G158 as it relates to the lack of POCs in place for private pay patients and other patients. 3. The administrator had not ensured a system had been developed and implemented to effectively coordinate care with outside entities. Refer to G143 as it relates to the lack of care coordination for patients. 4. The administrator had not ensured occupational therapists would be available to provide services to patients. Refer to G185 as it relates to the lack of OT services provided to patients, who had orders to receive such services.	G 133	ensured by an audit completed within 48 hours after the completed admit by a Registered Nurse. Weekly chart audits will be completed by a Registered Nurse on patients following admit to ensure compliance to the plan of care. Each patients chart will be audited at a minimum of bi-monthly to ensure compliance to plan of care. The administrator will ensure that the audits are being completed and bi-monthly IDT's are being held to coordinate cares.	

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G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and agency policies, it was determined the agency failed to ensure care was effectively coordinated with RCF's that also provided care to 2 of 2 agency patients (#3 and #4). Further, it was determined the agency failed to ensure care was effectively coordinated with OT and/or SW services for 3 of 4 patients (#1, #7, and #10) who received OT and/or SW services. This prevented agency and facility staff from working together to improve the health of patients. The findings include: 1. Patient #4 was a 69 year old female with diagnoses of type II diabetes and chronic kidney disease. Her SOC was 11/19/08. Agency nursing notes documented she was being seen twice a day for insulin injections. Documentation of coordination of care between the agency and an RCF where the patient lived was not present in the patient record. The Patient Care Coordinator, interviewed on 12/2/08 at 9:50 AM, confirmed there was no documentation of care coordination. A visit was made to the RCF on 12/3/08 at 8:15 AM and the facility nurse was interviewed. The nurse stated agency staff had not provided the RCF with a copy of the patient's POC or other written information regarding the patient's care. The nurse stated the RCF had requested this information from the agency but it	G 143	G143- The administrator will ensure that all patients receive care according to the initial home health orders and plan of care, and that all services are being coordinated effectively with all those involved in the patients care. Agency will also coordinate all services being provided including therapy services and with the facility in which the patient is residing. The facilities will have access to the appropriate documentation to allow coordination of care, including the plan of care, verbal orders, daily clinical notes, and other documents deemed necessary to the coordination of care. This will be done according to Agency's policy #2030. Agency's staff has been inserviced and are compliant as of January 6, 2009. (attachment B, Agency's Policy and Procedure #2030 Coordination of Services) Agency's delegated representative from the administrator will follow up bi-monthly will all facilities where agency is serving patients. Agency's representative will audit the facility chart for the presence of signed plan of care, updated orders, med sheets, coordination of care plans	1/6/2009

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G 143	Continued From page 4 had not been provided. 2. Patient #3 was a 90-year-old female with a SOC date of 11/24/08, and was a current patient on 12/02/08. She was admitted to the home health agency for monitoring and treatment of right foot cellulitis. The patient's POC, dated 11/24/08, stated the patient resided in an RCF and the agency's nurse was seeing the patient 2 times a week. The patient was also receiving PT services 2 times a week. During a visit to the RCF on 12/2/08 at 9:00 AM, the patient's RCF record was reviewed. The patient's record did not contain any documented evidence of coordination of care. The RCF's NSA did not state the patient was receiving home health services and cares and did not document coordination of services. On 12/2/08 at 9:40 AM, the home health nurse stated that she had not met or talked with the RCF's nurse nor did she know her name. A policy which outlined how staff were to coordinate care with facilities where patients lived was not present in the policy manual. The Patient Care Coordinator, interviewed on 12/10/08 at 11:15 AM, stated the agency did not have a policy which addressed coordination of care with outside entities such as RCFs. The agency failed to coordinate services with the RCF. 3. Patient #1 was a 66-year-old female with a SOC date of 2/1/08. She was admitted to the home health agency following a hospitalization where she was found to have a minimally displaced femoral neck fracture and underwent a right hemiarthroplasty after falling at home. The patient was discharged from the agency's service on 3/6/08. A nursing summary, dated 2/1/08, stated the agency was to provide OT services. The patient's record contained a physician's order	G 143	with the facility, that staff is coordinating cares with the facility, and policy #2030 is being followed. If non-compliance is found the agency's representative will notify the administrator for follow up to maintain compliance.	

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G 143	Continued From page 5 dated 1/31/08, requesting the agency to provide "Occupational Therapy." The record did not contain documented evidence that the agency had provided an OT evaluation or OT treatment to the patient. On 12/2/08 at 1:23 PM, the Clinical Administrator confirmed the patient had not received an OT evaluation and/or treatment. He stated that the agency was having trouble getting OT services in outlying towns. The agency failed to coordinate services to insure the patient received an OT evaluation or treatment. 4. Patient #7 was a 71-year-old female with a SOC date of 11/24/08, and was a current patient as of 12/3/08. She was admitted to the home health agency following a left hip surgery on 11/11/08. The patient's record contained a physician's order dated 11/19/08, requesting the agency to provide "Occupational Therapy." On 12/2/08, a second order, by a second physician was written for the patient to receive "Occupational Therapy for rehabilitation of hip replacement." As of 12/03/08, the patient had not received an OT evaluation and/or treatment. On 12/2/08 at 8:00 AM, the Clinical Administrator stated the physical therapist had assessed the patient, (on 11/24/08), and decided the patient would not benefit from OT services. He confirmed the patient had not received an OT evaluation or treatment. The agency failed to coordinate services to insure the patient received an OT evaluation or treatment. 5. Patient #10 was a 90-year-old female with a SOC date of 9/23/08. She was discharged on 11/13/08. She was admitted to the home health agency due to being a high fall risk, increased fatigue, weakness, CVA, depression and confusion. The nursing assessment dated	G 143		

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G 143	Continued From page 6 9/23/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, transferring, ambulation, medications, meals, housekeeping, and laundry. The patient's record contained a physician's order that was not dated, requesting the agency to provide "Occupational Therapy." The record did not contain documented evidence that she had received an OT evaluation and/or OT treatment. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed the patient had not received an OT evaluation. The record did not contain documentation that the OT had been notified of the referral. The agency failed to coordinate services and the patient did not receive an OT evaluation and/or treatment. Further, Patient #10's nursing assessment dated 9/23/08, stated the patient was depressed. The patient's record contained a physician's order, dated 9/23/08, requesting the agency to provide a SW consult. The record did not contain documented evidence that the patient was provided a SW consult. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed the patient had not received an SW consult. 6. On 12/3/08 at 1:50 PM, the Coordination Nurse was interviewed. She stated that IDT meetings were held weekly but only nursing attended the meetings. She stated that if PT and OT did not get their notes in it caused problems with coordination. She reviewed Patient #7s and #10s record. She stated the agency needed a better checks and balance process for OT referrals and coordination of services.	G 143		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 156		

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G 156	Continued From page 7 This CONDITION is not met as evidenced by: Based on staff interview and review of patients' clinical records and agency policies, it was determined the agency failed to ensure systems had been developed and implemented to plan for patients' care. The findings include: Refer to G158 as it relates to the failure of the agency to ensure POCs were developed for private pay and other patients. The cumulative effect of these negative systemic facility practices resulted in the agency's inability provide direction to staff who were caring for patients.	G 156	G 156/G158 The administrator will ensure that all patients referred to agency will be appropriately assessed and admitted to the agency according to policy and procedure #2008 (Attachment A). The administrator will also ensure that following the evaluation, a hand written Plan of Care will be sent to the physician for signature for orders of the home health disciplines in the interim time period that the 485/plan of care is being processed, audited, and data entried by the agency (This form can be found as attachment C). The administrator will also ensure that the physician will be notified of any missed visits that are not following the Plan of Care (see attachment D). All appropriate staff have been inserviced on these policy and procedures and are compliant as of January 6, 2009. This will be ensured by an audit completed within 48 hours after the completed admit by a Registered Nurse. Weekly chart audits will be completed by a Registered Nurse on all patients following admit to ensure compliance to the plan of care. Each patients chart will be audited at a minimum of bi-	1/6/2009
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to develop, implement, and/or provide services consistent with the POCs for 2 of 3 private pay patients (#8 and #14) and 7 of 12 non-private pay patients (#1, #3 #4, #5, #7, #10, and #15) whose records were reviewed. This resulted in the inability of the agency to ensure care was provided in a systematic manner. The findings include: 1. Patient #8 was a 14 year old male who was admitted following hospitalization for treatment of injuries received in a motor vehicle accident.	G 158		1/6/2009

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G 158	Continued From page 8 These injuries included several fractures and internal injuries. His SOC was 10/31/08. As of 12/2/08, he did not have a comprehensive POC. The Clinical Administrator, interviewed on 12/2/08 at 11:30 AM, stated the patient was a private pay patient. The administrator said agency staff did not normally develop POCs for private pay patients. 2. Patient #14 was a 20-year-old male with a SOC date of 10/21/08. He was admitted to the home health agency following a hospitalization after he was involved in an accident. The patient's inpatient consultation, dated 10/12/08, documented the patient had injuries to his right lower extremity which included fractures as well as skin injuries. The nursing notes documented that, while receiving home health services, the patient was seen at a wound clinic for continued treatment of his skin grafts and had a wound-vac in place. The patient was a current patient as of 12/2/08. The patient's record did not include a POC. On 12/3/08 at 1:20 PM, the Clinical Administrator reviewed the patient's record. He confirmed a POC had not been developed and said it was not a normal practice to develop a POC for private pay patients. 3. Patient #3 was a 90-year-old female with a SOC date of 11/24/08, and was a current patient as of 12/02/08. She was admitted to the home health agency for monitoring and treatment of right foot cellulitis. The medical record contained an "Intake/Referral Form", dated 11/24/08 that documented the agency's nurse was to seen the patient 2 times a week. The patient resided in an RCF, and was also receiving PT services 2 times a week. Review of the patient's record documented that the agency had not developed a	G 158	monthly to ensure compliance to plan of care. The administrator will ensure that the audits are being completed and bi-monthly IDT's are being held to coordinate cares.	

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G 158	Continued From page 9 POC for Patient #3. Further, the record did not contain physician's orders for nursing and PT services. The record only contained an order written by a PA, dated 11/22/08, for a "Home Evaluation". This was confirmed by interview with the RN assigned to the patient, on 12/2/08 at 9:00 AM. The agency failed to develop and follow a POC. 4. Patient #4 was a 69 year old female with diagnoses of type II diabetes and chronic kidney disease. Her SOC was 11/19/08. Nursing notes documented she was being seen twice a day for insulin injections. As of 12/1/08, 12 days after the SOC, a POC had not been developed by agency staff. The Director of Home Care, interviewed on 12/1/08 at 3:15 PM, stated the POC had not been completed because staff had been too busy over the Thanksgiving holiday. 5. Patient #5 was an 88 year old female with diagnoses of joint pain and dementia. Her SOC was 9/24/08. Her new certification period started 11/23/08. Her POC was not completed until 12/1/08, 8 days after the certification period started. The Clinical Administrator, interviewed on 12/2/08 at 10:30 AM, stated the POC had not been completed until 12/1/08. 6. Patient #7 was a 71-year-old female with a SOC date of 11/24/08. She was a current patient as of 12/02/08. She was admitted to the home health agency following a left hip surgery on 11/11/08. The patient had a history of diabetes mellitus, pernicious anemia, hypertension, back surgery. She had been started on anticoagulation therapy after her surgery. The physician ordered skilled nursing, OT and PT services on 11/19/08. The "Comprehensive Assessment", dated	G 158		

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	137110	A. BUILDING _____ B. WING _____	12/03/2008

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G 158	Continued From page 10 11/24/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, medications, meals, housekeeping and laundry. The patient also had a surgical wound that needed monitoring. Review of the patient's record documented that the agency had not developed a POC for patient #7. On 12/3/08 at 10:30 AM, the Clinical Administrator stated the patient's POC had not been developed due to the holiday and the fact that the agency had admitted several of new patients during that past week. 7. The agency maintained a "PHYSICIAN LOG BOOK" for tracking documents sent to physicians. The log book tracked POCs sent between 10/3/08 and 12/1/08. The Office Manager maintained the the log. The log book documented 10 plans of care that were not developed until between 8 and 13 days after their SOC or certification dates. The Office Manager confirmed this during an interview on 12/2/08 at 10:00 AM. 8. Patient #1 was a 66-year-old female with a SOC date of 2/1/08. She was admitted to the home health agency following a hospitalization for a minimally displaced femoral neck fracture and underwent a right hip surgery. The patient was discharged from the agency's service on 3/6/08. The patient's POC, dated 2/1/08, stated the HHA would see the patient 1-2 times a week for six weeks. The patient was seen by the HHA on 2/8/08, and was not seen again by the HHA until 2/29/08. The patient did not receive HHA services during the 2nd, 3rd and the 4th week of service. The record did not contain documented evidence that the agency had notified the physician of the missed visits. On 12/2/08 at 1:23 PM, the Clinical Administrator confirmed the	G 158		

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G 158	Continued From page 11 missed visits. She stated the physician was not notified. She said it was not the agency's practice to notify physicians of patient missed visits. The agency provided fewer visits than what the physician had ordered and therefore, the agency altered the POC and should have notified the physician. 9. Patient #10 was a 90-year-old female with a SOC date of 9/23/08. She was discharged on 11/13/08. She was admitted to the home health agency due to being a high fall risk. The nursing assessment dated 9/23/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, transferring, ambulation, medications, meals, housekeeping and laundry. The patient's POC dated 9/23/08, stated the HHA would see the patient once a week for six weeks. The patient was seen by the HHA on 9/27/08 and was not seen again by the HHA until 10/20/08. The patient did not receive HHA services during the 2nd, 3rd and the 4th week of service. Additionally, the HHA saw the patient on 11/10/08, during the 8th week of service. The agency did not have physician's order for aide services for week 8. The record did not contain documentation that the agency had notified the physician of the extra or missed visits. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed the physician was not informed of the extra or missed visits. The agency provided fewer and extra visits than what the physician had ordered and therefore, the agency altered the POC without notifying the physician. Further, the nursing assessment dated 9/23/08, stated the patient was depressed. The patient's record contained a physician's order, dated 9/23/08, requesting the agency to provide a SW consult. The record did not contain documentation that the	G 158		

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G 158	Continued From page 12 patient was provided a social worker's consult. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed the patient had not received an SW consult. 10. Patient #15 was an 80-year-old male with a SOC date of 10/15/08. He was a current patient as of 12/2/08. He was admitted to the home health agency due to increased confusion and weakness. The patient's POC, dated 10/16/08, stated the HHA would see the patient 2 to 3 times a week for six weeks starting on 10/19/08. The patient was seen by the HHA on 11/14/08 and was not seen again until 11/28/08. The patient did not receive HHA services during the 5th week of service. The record did not contain documentation that the agency had notified the physician of the missed visit. On 12/2/08 at 1:10 PM, the Clinical Administrator confirmed the physician was not informed of the missed visit. The agency provided fewer visits than the physician ordered, therefore the agency altered the POC and should have notified the physician.	G 158		
G 185	484.32 THERAPY SERVICES Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the agency failed to ensure therapy services were provided as ordered by the physician for 3 of 4 sampled patients, who had orders to receive OT services (#1, #7 and #10). This resulted in omitted	G 185	G 185- The administrator will ensure that all ordered disciplines including therapy and social services will be started within the appropriate time frame and coordinated according to Policy and Procedure #2030 (coordination of services). All appropriate staff have been inserviced on this policy and are compliant as of January 6, 2008. All appropriate staff have been inserviced on these policy and procedures and are	1/6/2009

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G 185	Continued From page 13 evaluations and treatment for those patients. The findings include: 1. Patient #1 was a 66-year-old female with a SOC date of 2/1/08. She was admitted to the home health agency following a hospitalization for a minimally displaced femoral neck fracture and underwent a right hip surgery. The patient was discharged from the agency's service on 3/6/08. A "Intake/Referral" form, dated 2/1/08, written by a nurse stated, the agency was to provide PT and OT services to improve strength, mobility and improve her gait and range of motion. The patient's POC dated 2/1/08, stated the patient received assistance with her activities of daily living from a "couple who came in and helped her at home" and the agency's HHA. The patient's record contained a physician's order dated 1/31/08, requesting the agency to provide "Occupational Therapy." The record did not contain documented evidence that the agency had provided an OT evaluation or OT treatment to the patient. On 12/2/08 at 1:23 PM, the Clinical Administrator confirmed the patient had not received an OT evaluation or treatment and the physician had not been notified of this. Further, he stated that the agency was having trouble providing OT services in outlying towns. The patient did not receive an OT evaluation and/or treatment per physician's orders. 2. Patient #7 was a 71-year-old female with a SOC date of 11/24/08, and was a current patient as of 12/02/08. She was admitted to the home health agency following left hip surgery on 11/11/08. The nursing assessment, dated 11/24/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, medications, meals, housekeeping and	G 185	compliant as of January 6, 2009. This will be ensured by an audit completed within 48 hours after the completed admit by a Registered Nurse. Weekly chart audits will be completed by a Registered Nurse on all patients following admit to ensure compliance to the plan of care. Each patients chart will be audited at a minimum of bi-monthly to ensure compliance to plan of care. The administrator will ensure that the audits are being completed and bi-monthly IDT's are being held to coordinate cares.	

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G 185	Continued From page 14 laundry. The patient's record contained a physician's order dated 11/19/08, requesting the agency to provide "Occupational Therapy." On 12/2/08, a second order, by a different physician was written for the patient to receive "Occupational Therapy for rehabilitation of hip replacement." As of 12/03/08, the patient had not received an OT evaluation and/or treatment. On 12/2/08 at 8:00 AM, the Clinical Administrator stated the physical therapist had assessed the patient on 11/24/08 and decided the patient would not benefit from OT services. He confirmed the patient had not received an OT evaluation or treatment and said the physician had not been notified of this. The patient did not received an OT evaluation and/or treatment per physicians' orders. 3. Patient #10 was a 90-year-old female with a SOC date of 9/23/08. She was discharged on 11/13/08. She was admitted to the home health agency due to being a high fall risk, increased fatigue, weakness, CVA, depression and confusion. The nursing assessment dated 9/23/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, transferring, ambulation, medications, meals, housekeeping, and laundry. The patient's record contained a physician's order, that was not dated, requesting the agency to provide "Occupational Therapy." The record did not contain documentation that she had received an OT evaluation and/or OT treatment. On 12/2/08 at 3:57 PM, the Clinical Administrator reviewed the patient's record and confirmed there was not documentation that the patient had received an OT evaluation. He further could not find documented evidence that the physician had been notified of the above. The patient did not	G 185		

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G 185	Continued From page 15 revive an OT evaluation and/or treatment per physician's orders.	G 185		
G 228	484.36(d)(1) SUPERVISION If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and agency policies, it was determined that, the agency failed to ensure that RNs or physical therapists had made supervisory visits to patients' homes no less frequently than every 2 weeks, for 5 of 8 sampled patients (#1, #5, #9, #10 and #15) who received home health aide services. This prevented the agency from ensuring HHAs provided safe and effective care to patients. The findings include: 1. Patient #1 was a 66-year-old female with a SOC date of 2/1/08. She was admitted to the home health agency following a hospitalization when she was found to have a minimally displaced femoral neck fracture and underwent hip surgery. The patient was discharged from the agency's service on 3/6/08. The patient's POC, dated 2/1/08, stated the HHA would see the patient 1-2 times a week for six weeks. The patient also received PT services 1 time for the first week and 2-3 times a week for 6 weeks. The	G 228	G 228- The administrator will ensure that all aide supervisory visits will be done by the appropriate supervisor either a Registered Nurse or a Physical Therapist, at least every 14 days. All supervising staff have been inserviced on this and are compliant as of this day January 6, 2008. (see attached policy and procedure #8047 Exhibit E) Weekly chart audits will be completed by a Registered Nurse on all patients following admit to ensure compliance to the plan of care. Each patients chart will be audited at a minimum of bi-monthly to ensure compliance to plan of care and supervisory visits. The administrator will ensure that the audits are being completed and bi-monthly IDT's are being held to coordinate cares.	1/6/2009

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G 228	Continued From page 16 patient was seen by the HHA on 2/5, 2/7 and 2/29/08. The record did not contain documentation that PT staff had made a supervisory HHA visit during her time of services. On 12/2/08 at 1:23 PM, the Clinical Administrator confirmed that the PT had not made a supervisory HHA visit to the patient's home. The agency's policy for HHA supervision was not dated or titled. Page 69 stated, "Make supervisory visits...every two weeks.." This policy was not followed. 2. Patient #9 was an 86-year-old male with a SOC date of 7/22/08. He was admitted to the home health agency following a hospitalization for a myocardial infarction. The patient was a current patient as of 12/2/08. The patient's POC dated 7/22/08, stated the HHA would see the patient 1-2 times a week for nine weeks. However, HHA services were discontinued after six weeks of service. The patient was also receiving skilled nursing services 1 to 3 times a week for 3 weeks. PT was also to see the patient 2 to 3 times a week for 9 weeks. The patient was seen by the HHA on 7/25, 7/28, 8/1, 8/4, 8/8, 8/12, 8/15, 8/19, 8/21 and 8/26/08. The record did not contain documentation that nursing or PT staff had made the necessary supervisory HHA visits during the six weeks of HHA's service. On 12/2/08 at 2:21 PM, the Clinical Administrator confirmed the supervisory visits had not been completed. 3. Patient #10 was a 90-year-old female with a SOC date of 9/23/08. She was discharged on 11/13/08. She was admitted to the home health agency due to being a high fall risk, increased fatigue, weakness, CVA, depression and confusion. The nursing assessment, dated 9/23/08, stated the patient needed "assistance	G 228		

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G 228	Continued From page 17 several times a day" with bathing, dressing, toileting, transferring, ambulation, medications, meals, housekeeping, and laundry. The patient's POC, dated 9/23/08, stated the HHA would see the patient once a week for six weeks. The patient was also receiving skilled nursing services. The patient was seen by the HHA on 9/27, 10/20, 10/27 and 11/10/08. The record did not contain documentation that nursing staff had made supervisory HHA visits. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed that the nurse had not made the supervisory HHA visits to the patient's home. 4. Patient #15 was an 80-year-old male with a SOC date of 10/15/08, and was a current patient during the time of the survey. He was admitted to the home health agency due to increased confusion and weakness. The patient's POC, dated 10/16/08, stated the HHA would see the patient 2 to 3 times a week for six weeks starting on 10/19/08. The patient was also receiving skilled nursing services. The patient was seen by the HHA on 10/19, 10/21, 10/24, 10/28, 10/31, 11/7, 11/11, 11/14, 11/18 and 11/23/08. The record did not contain documented evidence that nursing staff had made supervisory HHA visits. On 12/2/08 at 1:10 PM, the Clinical Administrator confirmed that nursing staff had not made supervisory visits to the patient's home. 5. Patient #5 was an 88 year old female with diagnoses of joint pain and dementia. Her SOC was 9/24/08. Home health aide notes documented visits on 9/30, 10/1, 10/7, 10/9, 10/14, 10/16, 10/23, 10/28, 10/30, 11/4, 11/6/, and 11/18. Nursing visits were documented on 9/24/08 and 10/1/08. Weekly PT visits were documented 9/29/08 through 11/19/08. During	G 228		

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G 228	Continued From page 18 that time, no supervisory visits by a registered nurse or a physical therapist were documented. The Patient Care Coordinator, interviewed on 12/2/08 at 9:30 AM, reviewed the record and stated the supervisory visits were not documented.	G 228		
G 334	484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to ensure a comprehensive assessment was completed in a timely manner, consistent with the patient's immediate needs, for 2 of 3 sampled patients (#8 and #14), who were private pay patients. In addition, the agency failed to ensure a comprehensive assessment was completed for 1 of 1 other patient (#4) with complex teaching needs. This prevented staff from ensuring all of the patients' needs were planned for. The findings include: 1. Patient #8 was a 14 year old male who was admitted following hospitalization for treatment of injuries received in a motor vehicle accident. These injuries resulted in multiple fractures, including fractures of the left arm and leg, and internal injuries. His SOC was 10/31/08. A hand written "SN Start of Care/Resumption of Care 1.60" form, dated 10/31/08, was included in the record. This served as the comprehensive assessment. The assessment was not signed. The assessment was not complete. The Patient	G 334	G-334 The administrator will ensure that all patients regarding payor source will be admitted with Medicare standards, including a comprehensive assessment and development of a plan of care according to Agency's Policy and Procedure #2008. All admitting staff have been inserviced and are compliant as of this day January 6, 2009. (attachment A, Agency's Policy and Procedure #2008 Assessment/Plan of Care) All appropriate staff have been inserviced on these policy and procedures and are compliant as of January 6, 2009. This will be ensured by an audit completed within 48 hours after the completed admit by a Registered Nurse. Weekly chart audits will be completed by a Registered Nurse on all patients following admit to ensure compliance to the plan of care. Each patients chart will be audited at a minimum of bi-monthly to ensure	1/6/2009

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G 334	Continued From page 19 Care Coordinator, interviewed on 12/10/08 at 9:00 AM, stated at least one of Patient #8's parents were incarcerated and he had run away from the other parent. The Patient Care Coordinator said the patient lived with his aunt. She said the aunt was working to obtain custody of the minor child. The Clinical Administrator was not sure if the aunt had legal guardianship of the patient or not. This information was not included in the assessment. The assessment stated an "Other family member" took "lead responsibility for providing or managing the patient's care..." The assessment did not state if that person was with the patient at all times or whether the patient needed such assistance. The Patient Care Coordinator stated the patient did not attend school due to his injuries. The patient's educational status and services were not assessed. A home visit was made by the surveyor on 12/2/08 at 1:00 PM. The patient lived in a house with several steep stairs in front and narrow winding stairs leading to the garage. The patient was non-weight bearing when he was admitted. At the time of the visit he was ambulating with a walker with supervision. He was sleeping in a hospital bed in the living room but he stated he was anxious to move back into a room over the garage. This required him to go down stairs into the garage and then climb very narrow steep wooden stairs to the second floor over the garage. A hand rail extended only half way down the stairs. An assessment of the environment was also not documented. This was confirmed by interview with the Patient Care Coordinator, on 12/10/08 at 9:00 AM. 2. Patient #14 was a 20-year-old male with a SOC date of 10/21/08. He was admitted to the home health agency following hospitalization after he was involved in an accident which resulted in	G 334	monthly IDT's are being held to coordinate cares. compliance to plan of care. The administrator will ensure that the audits are being completed and bi-	

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G 334	Continued From page 20 injuries to his right lower extremity, including fractures as well as skin injuries. The patient was a current patient as of 12/3/08. A comprehensive assessment had not been documented. On 12/3/08 at 1:20 PM, the Clinical Administrator reviewed the patient's record. He confirmed no assessment was completed and stated it was not a normal practice to do a comprehensive assessment for private pay patients. The agency's policy for comprehensive assessments was not dated or titled. Page 54 stated, "An initial visit shall be made by a Licensed Professional who will perform the comprehensive assessment..." This policy had not been followed. 3. Patient #4 was a 69 year old female with diagnoses of type II diabetes and chronic kidney disease. Her SOC was 11/19/08. Nursing notes documented she was being seen twice a day for insulin injections. The Patient Care Coordinator was interviewed on 12/2/08 at 9:50 AM. She stated the goal of the agency was to teach the patient to self administer her insulin. The Patient Care Coordinator said the patient had previously been under the care of another home health agency that had been unsuccessful at teaching the patient to self administer. An assessment of the patient's ability to self administer her insulin was not present in the record. The Patient Care Coordinator stated the patient was legally blind. The Patient Care Coordinator said the patient had not been evaluated to determine if the patient was capable of learning to self administer insulin. For example, the agency had not assessed whether or not the patient had the fine motor skills or visual acuity necessary to self administer. The patient resided in an RCF. The agency had not determined what help the facility was willing to provide the patient. For example, the agency had	G 334		

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G 334	Continued From page 21 not assessed whether the facility was willing to assist the patient to monitor her blood glucose levels. This prevented the agency from developing a plan to teach the patient to self administer her insulin.	G 334		

Bureau of Facility Standards

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Idaho state licensure survey of your home health agency. Surveyors conducting the licensure review were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Acronyms used in this report include: CVA = cerebrovascular accident (stroke) HHA = Home Health Aide NSA = Negotiated Service Agreement OT = Occupational Therapy PA = Physician Assistant POC = Plan of Care PT = Physical Therapy RCF = Residential Care Facility SN = Skilled Nursing SOC = Start of Care SW = Social Worker	N 000		
N 001	03.07020.01. ADMIN.GOV.BODY 020. ADMINISTRATION - GOVERNING BODY. N001 01. Scope. The home health agency shall be organized under a governing body, which shall assume full legal responsibility for the conduct of the agency. This Rule is not met as evidenced by: Based on staff interview and review of patients' clinical records and agency policies, it was determined the governing body failed to ensure systems had been developed and implemented	N 001	N001- The governing body of Access Home Care has proper systems in place as of this day January 6, 2009 to ensure all basic care and services are met for the patient. This will be evidenced by the following plan of corrections that proceed in this document.	1/6/2009

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N 001	Continued From page 1 to provide basic care and services to patients and to coordinate care. The findings include: 1. Refer to N44 as it relates to the failure of the agency to ensure the administrator provided sufficient organization and direction to agency staff to ensure basic services and processes would be defined and provided. 2. Refer to N51 as it relates to the failure of the agency to ensure current CPR certifications were maintained for employees who provided direct care to patients. 3. Refer to N62 as it relates to the failure of the agency to ensure care was effectively coordinated with outside entities that also provided care to agency patients. 4. Refer to G123 as it relates to the failure of the agency to ensure OT services were provided as ordered. 5. Refer to N152 as it relates to the failure of the agency to ensure POCs were developed for private pay and other patients. The cumulative effect of these negative systemic agency practices resulted in the agency's inability to provide consistent services to patients.	N 001		
N 044	03.07021. ADMINISTRATOR N044 021. ADMINISTRATOR. An administrator shall be appointed by the governing body and shall be responsible and accountable for implementing the policies and programs approved by the governing body.	N 044	N044- The administrator will ensure that all patients receive care according to the initial home health orders and plan of care, and that all services are being coordinated effectively with all those	1/6/2009

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N 044	Continued From page 2 This Rule is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to ensure the administrator provided sufficient organization and direction to agency staff to ensure basic services and processes would be defined and provided. The agency, through the administrator, failed to ensure that systems were in place to ensure patients were comprehensively assessed, that that systems were in place to ensure patients had POCs to direct staff in the provision of care, that systems were in place to ensure care was coordinated with other providers who furnished care to agency patients, and that systems were in place to ensure occupational therapy services were available to all patients. These omissions affected the care of 8 of 15 patients (#1, #3, #4, #5, #7, #8, #10, and #14) whose care was reviewed. The findings include: 1. The administrator had not ensured a system had been developed and implemented to provide comprehensive assessments to private pay and other patients. This affected the care of 2 of 3 private pay patients (#8 and #14). Examples include: * Patient #8 was a 14 year old male who was admitted following hospitalization for treatment of injuries received in a motor vehicle accident. These injuries resulted in multiple fractures, including fractures of the left arm and leg, and internal injuries. His SOC was 10/31/08. A hand written "SN Start of Care/Resumption of Care 1.60" form, dated 10/31/08, was included in the record. This served as the comprehensive assessment. The assessment was not signed. The assessment was not complete. The Patient	N 044	involved in the patients care. Agency will also coordinate all services being provided including therapy services and with the facility in which the patient is residing. The facilities will have access to the appropriate documentation to allow coordination of care, including the plan of care, verbal orders, daily clinical notes, and other documents deemed necessary to the coordination of care. This will be done according to Agency's policy. Agency's staff has been inserviced and are compliant as of January 6, 2009. (attachment B, Agency's Policy and Procedure #2030 Coordination of Services)	

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N 044	Continued From page 3 Care Coordinator, interviewed on 12/10/08 at 9:00 AM, stated at least one of Patient #8's parents were incarcerated and he had run away from the other parent. The Patient Care Coordinator said the patient lived with his aunt. She said the aunt was working to obtain custody of the minor child. The Clinical Administrator was not sure if the aunt had legal guardianship of the patient or not. This information was not included in the assessment. The assessment stated an "Other family member" took "lead responsibility for providing or managing the patient's care..." The assessment did not state if that person was with the patient at all times or whether the patient needed such assistance. The Patient Care Coordinator stated the patient did not attend school due to his injuries. The patient's educational status and services were not assessed. A home visit was made by the surveyor on 12/2/08 at 1:00 PM. The patient lived in a house with several steep stairs in front and narrow winding stairs leading to the garage. The patient was non-weight bearing when he was admitted. At the time of the visit he was ambulating with a walker with supervision. He was sleeping in a hospital bed in the living room but he stated he was anxious to move back into a room over the garage. This required him to go down stairs into the garage and then climb very narrow steep wooden stairs to the second floor over the garage. A hand rail extended only half way down the stairs. An assessment of the environment was also not documented. This was confirmed by interview with the Patient Care Coordinator, on 12/10/08 at 9:00 AM. * Patient #14 was a 20-year-old male with a SOC date of 10/21/08. He was admitted to the home health agency following hospitalization after he was involved in an accident which resulted in	N 044		

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N 044	Continued From page 4 injuries to his right lower extremity, including fractures as well as skin injuries. The patient was a current patient as of 12/3/08. A comprehensive assessment had not been documented. On 12/3/08 at 1:20 PM, the Clinical Administrator reviewed the patient's record. He confirmed no assessment was completed and stated it was not a normal practice to do a comprehensive assessment for private pay patients. The agency's policy for comprehensive assessments was not dated or titled. Page 54 stated, "An initial visit shall be made by a Licensed Professional who will perform the comprehensive assessment..." This policy had not been followed. 2. The administrator had not ensured a system had been developed and implemented to develop plans to direct the care provided to patients. Refer to G152 as it relates to the lack of POCs in place for 2 of 3 private pay patients (#8 and #14) and 4 of 12 other patients (#3 #4, #5, and #7). The Clinical Administrator, interviewed on 12/2/08 at 11:30 AM, stated comprehensive POCs were not developed for private pay patients. He also stated the other missing POCs had been delayed due to the Thanksgiving holiday, however, a "PHYSICIAN LOG BOOK" documented 10 plans of care that were not developed until between 8 and 13 days after patients' SOC or certification dates between 10/3/08 and 12/1/08. . 3. The administrator had not ensured a system had been developed and implemented to effectively coordinate care with outside entities. Refer to N62 as it relates to the lack of care coordination for patients. A policy addressing coordination of care with facilities where patients lived was not present in the policy manual. The Patient Care Coordinator, interviewed on	N 044		

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N 044	Continued From page 5 12/10/08 at 11:15 AM, stated the agency had not developed such a policy. 4. The administrator had not ensured occupational therapists would be available to provide services to patients. Refer to N123 as it relates to the lack of OT services provided to 3 of 4 sampled patients (#1, #7 and #10), who had orders to receive such services. On 12/2/08 at 1:23 PM, the Clinical Administrator confirmed the patients had not received OT evaluations or treatment and the physician had not been notified of this. Further, he stated that the agency was having trouble providing OT services in outlying towns.	N 044		
N 051	03.07021. ADMINISTRATOR N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations. This Rule is not met as evidenced by: Based on staff personnel files, agency contracts and staff interview it was determined the HHA	N 051	N051- The administrator will ensure that all personnel records of staff working directly with patients shall be updated and current per agency policy and procedure. All staff will have a current cpr card, and if the cpr card is not renewed in the appropriate amount of time the staff member will no longer be able to have direct patient contact until the CPR certificate is active. All staff are compliant as of this day January 6, 2009. (see Policy and Procedure # 8007 exhibit F)	1/6/2009

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N 051	Continued From page 6 failed to ensure the administrator maintained documentation of current CPR certifications for 4 of 12 employees (#7, #8, #9 and # 11) whose employee files were reviewed. By not ensuring that employees had current CPR the HHA could not ensure that CPR could be administered properly by the licensed staff. The findings include: The agency failed to retain contractor personnel files to include current CPR certification as follows: 1. Employee #7 was a SW whose date of hire was 6/08. The employee's personal record did not contain a CPR certification. 2. Employee #8 was a SW whose date of hire was 6/07. The employee's personal record did not contain a CPR certification. 3. Employee #9 was a Speech Therapist who was contracted to the agency on 10/07. The employee's personal record did not contain a CPR certification. 4. Employee #12 was an OT who was contracted to the agency on 11/08. The employee's personal record did not contain a CPR certification. On 12/03/08 at 10:40 PM, the Director of Home Care stated that he knew some employees did not have a current CPR card and a class is scheduled.	N 051		
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall	N 062	N062- The administrator will ensure that all	1/6/2009

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N 062	Continued From page 7 assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Based on staff interview and review of clinical records and agency policies, it was determined the agency failed to ensure care was effectively coordinated with RCF's that also provided care to 2 of 2 agency patients (#3 and #4). Further, it was determined the agency failed to ensure care was effectively coordinated with OT and/or SW services for 3 of 4 patients (#1, #7, and #10) who received OT and/or SW services. This prevented agency and facility staff from working together to improve the health of patients. The findings include: 1. Patient #4 was a 69 year old female with diagnoses of type II diabetes and chronic kidney disease. Her SOC was 11/19/08. Agency nursing notes documented she was being seen twice a day for insulin injections. Documentation of coordination of care between the agency and an RCF where the patient lived was not present in the patient record. The Patient Care Coordinator, interviewed on 12/2/08 at 9:50 AM, confirmed there was no documentation of care coordination. A visit was made to the RCF on 12/3/08 at 8:15 AM and the facility nurse was interviewed. The nurse stated agency staff had not provided the RCF with a copy of the patient's POC or other written information regarding the patient's care. The nurse stated the RCF had requested this information from the agency but it	N 062	patients receive care according to the initial home health orders and plan of care, and that all services are being coordinated effectively with all those involved in the patients care. Agency will also coordinate all services being provided including therapy services and with the facility in which the patient is residing. The facilities will have access to the appropriate documentation to allow coordination of care, including the plan of care, verbal orders, daily clinical notes, and other documents deemed necessary to the coordination of care. This will be done according to Agency's policy. Agency's appropriate staff have been inserviced and are compliant as of January 6, 2009. (attachment B, Agency's Policy and Procedure #2030 Coordination of Services Exhibit E)	

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N 062	Continued From page 8 had not been provided. 2. Patient #3 was a 90-year-old female with a SOC date of 11/24/08, and was a current patient on 12/02/08. She was admitted to the home health agency for monitoring and treatment of right foot cellulitis. The patient's POC, dated 11/24/08, stated the patient resided in an RCF and the agency's nurse was seeing the patient 2 times a week. The patient was also receiving PT services 2 times a week. During a visit to the RCF on 12/2/08 at 9:00 AM, the patient's RCF record was reviewed. The patient's record did not contain any documented evidence of coordination of care. The RCF's NSA did not state the patient was receiving home health services and cares and did not document coordination of services. On 12/2/08 at 9:40 AM, the home health nurse stated that she had not met or talked with the RCF's nurse nor did she know her name. A policy which outlined how staff were to coordinate care with facilities where patients lived was not present in the policy manual. The Patient Care Coordinator, interviewed on 12/10/08 at 11:15 AM, stated the agency did not have a policy which addressed coordination of care with outside entities such as RCFs. The agency failed to coordinate services with the RCF. 3. Patient #1 was a 66-year-old female with a SOC date of 2/1/08. She was admitted to the home health agency following a hospitalization where she was found to have a minimally displaced femoral neck fracture and underwent a right hemiarthroplasty after falling at home. The patient was discharged from the agency's service on 3/6/08. A nursing summary, dated 2/1/08, stated the agency was to provide OT services. The patient's record contained a physician's order	N 062		

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N 062	Continued From page 9 dated 1/31/08, requesting the agency to provide "Occupational Therapy." The record did not contain documented evidence that the agency had provided an OT evaluation or OT treatment to the patient. On 12/2/08 at 1:23 PM, the Clinical Administrator confirmed the patient had not received an OT evaluation and/or treatment. He stated that the agency was having trouble getting OT services in outlying towns. The agency failed to coordinate services to insure the patient received an OT evaluation or treatment. 4. Patient #7 was a 71-year-old female with a SOC date of 11/24/08, and was a current patient as of 12/3/08. She was admitted to the home health agency following a left hip surgery on 11/11/08. The patient's record contained a physician's order dated 11/19/08, requesting the agency to provide "Occupational Therapy." On 12/2/08, a second order, by a second physician was written for the patient to receive "Occupational Therapy for rehabilitation of hip replacement." As of 12/03/08, the patient had not received an OT evaluation and/or treatment. On 12/2/08 at 8:00 AM, the Clinical Administrator stated the physical therapist had assessed the patient, (on 11/24/08), and decided the patient would not benefit from OT services. He confirmed the patient had not received an OT evaluation or treatment. The agency failed to coordinate services to insure the patient received an OT evaluation or treatment. 5. Patient #10 was a 90-year-old female with a SOC date of 9/23/08. She was discharged on 11/13/08. She was admitted to the home health agency due to being a high fall risk, increased fatigue, weakness, CVA, depression and confusion. The nursing assessment dated 9/23/08, stated the patient needed "assistance	N 062		

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N 062	Continued From page 10 several times a day" with bathing, dressing, toileting, transferring, ambulation, medications, meals, housekeeping, and laundry. The patient's record contained a physician's order that was not dated, requesting the agency to provide "Occupational Therapy." The record did not contain documented evidence that she had received an OT evaluation and/or OT treatment. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed the patient had not received an OT evaluation. The record did not contain documentation that the OT had been notified of the referral. The agency failed to coordinate services and the patient did not receive an OT evaluation and/or treatment. Further, Patient #10's nursing assessment dated 9/23/08, stated the patient was depressed. The patient's record contained a physician's order, dated 9/23/08, requesting the agency to provide a SW consult. The record did not contain documented evidence that the patient was provided a SW consult. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed the patient had not received an SW consult. 6. On 12/3/08 at 1:50 PM, the Coordination Nurse was interviewed. She stated that IDT meetings were held weekly but only nursing attended the meetings. She stated that if PT and OT did not get their notes in it caused problems with coordination. She reviewed Patient #7s and #10s record. She stated the agency needed a better checks and balance process for OT referrals and coordination of services.	N 062		
N 119	03.07024.04.SK.NSG.SERV. N119 04. Supervisory Visits. A registered nurse or therapist makes a	N 119	N 119- The administrator will ensure that all	1/6/2009

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N 119	Continued From page 11 supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days. This Rule is not met as evidenced by: Based on staff interview and review of clinical records and agency policies, it was determined that, the agency failed to ensure that RNs or physical therapists had made supervisory visits to patients' homes no less frequently than every 2 weeks, for 5 of 8 sampled patients (#1, #5, #9, #10 and #15) who received home health aide services. This prevented the agency from ensuring HHAs provided safe and effective care to patients. The findings include: 1. Patient #1 was a 66-year-old female with a SOC date of 2/1/08. She was admitted to the home health agency following a hospitalization when she was found to have a minimally displaced femoral neck fracture and underwent hip surgery. The patient was discharged from the agency's service on 3/6/08. The patient's POC, dated 2/1/08, stated the HHA would see the patient 1-2 times a week for six weeks. The patient also received PT services 1 time for the first week and 2-3 times a week for 6 weeks. The patient was seen by the HHA on 2/5, 2/7 and 2/29/08. The record did not contain documentation that PT staff had made a supervisory HHA visit during her time of services. On 12/2/08 at 1:23 PM, the Clinical Administrator confirmed that the PT had not made a	N 119	aide supervisory visits will be done by the appropriate supervisor either an Registered Nurse or a Physical Therapist, at least every 14 days. All supervising staff have been inserviced on this and are compliant as of this day January 6, 2008. (see attached policy and procedure #8047)	

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	137110	A. BUILDING _____ B. WING _____	12/03/2008

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N 119	Continued From page 12 supervisory HHA visit to the patient's home. The agency's policy for HHA supervision was not dated or titled. Page 69 stated, "Make supervisory visits...every two weeks.." This policy was not followed. 2. Patient #9 was an 86-year-old male with a SOC date of 7/22/08. He was admitted to the home health agency following a hospitalization for a myocardial infarction. The patient was a current patient as of 12/2/08. The patient's POC dated 7/22/08, stated the HHA would see the patient 1-2 times a week for nine weeks. However, HHA services were discontinued after six weeks of service. The patient was also receiving skilled nursing services 1 to 3 times a week for 3 weeks. PT was also to see the patient 2 to 3 times a week for 9 weeks. The patient was seen by the HHA on 7/25, 7/28, 8/1, 8/4, 8/8, 8/12, 8/15, 8/19, 8/21 and 8/26/08. The record did not contain documentation that nursing or PT staff had made the necessary supervisory HHA visits during the six weeks of HHA's service. On 12/2/08 at 2:21 PM, the Clinical Administrator confirmed the supervisory visits had not been completed. 3. Patient #10 was a 90-year-old female with a SOC date of 9/23/08. She was discharged on 11/13/08. She was admitted to the home health agency due to being a high fall risk, increased fatigue, weakness, CVA, depression and confusion. The nursing assessment, dated 9/23/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, transferring, ambulation, medications, meals, housekeeping, and laundry. The patient's POC, dated 9/23/08, stated the HHA would see the patient once a week for six weeks. The patient was also receiving skilled nursing	N 119		

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N 119	Continued From page 13 services. The patient was seen by the HHA on 9/27, 10/20, 10/27 and 11/10/08. The record did not contain documentation that nursing staff had made supervisory HHA visits. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed that the nurse had not made the supervisory HHA visits to the patient's home. 4. Patient #15 was an 80-year-old male with a SOC date of 10/15/08, and was a current patient during the time of the survey. He was admitted to the home health agency due to increased confusion and weakness. The patient's POC, dated 10/16/08, stated the HHA would see the patient 2 to 3 times a week for six weeks starting on 10/19/08. The patient was also receiving skilled nursing services. The patient was seen by the HHA on 10/19, 10/21, 10/24, 10/28, 10/31, 11/7, 11/11, 11/14, 11/18 and 11/23/08. The record did not contain documented evidence that nursing staff had made supervisory HHA visits. On 12/2/08 at 1:10 PM, the Clinical Administrator confirmed that nursing staff had not made supervisory visits to the patient's home. 5. Patient #5 was an 88 year old female with diagnoses of joint pain and dementia. Her SOC was 9/24/08. Home health aide notes documented visits on 9/30, 10/1, 10/7, 10/9, 10/14, 10/16, 10/23, 10/28, 10/30, 11/4, 11/6/, and 11/18. Nursing visits were documented on 9/24/08 and 10/1/08. Weekly PT visits were documented 9/29/08 through 11/19/08. During that time, no supervisory visits by a registered nurse or a physical therapist were documented. The Patient Care coordinator, interviewed on 12/2/08 at 9:30 AM, reviewed the record and stated the supervisory visits were not documented.	N 119		

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N 123	Continued From page 14	N 123	N 123-	1/6/2009
N 123	03.07025.THERAPY SERV. N123 025. THERAPY SERVICES. Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care. This Rule is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the agency failed to ensure therapy services were provided as ordered by the physician for 3 of 4 sampled patients, who had orders to receive OT services (#1, #7 and #10). This resulted in omitted evaluations and treatment for those patients. The findings include: 1. Patient #1 was a 66-year-old female with a SOC date of 2/1/08. She was admitted to the home health agency following a hospitalization for a minimally displaced femoral neck fracture and underwent a right hip surgery. The patient was discharged from the agency's service on 3/6/08. A "Intake/Referral" form, dated 2/1/08, written by a nurse stated, the agency was to provide PT and OT services to improve strength, mobility and improve her gait and range of motion. The patient's POC dated 2/1/08, stated the patient received assistance with her activities of daily living from a "couple who came in and helped her at home" and the agency's HHA. The patient's record contained a physician's order dated 1/31/08, requesting the agency to provide "Occupational Therapy." The record did not contain documented evidence that the agency had provided an OT evaluation or OT treatment	N 123	The administrator will ensure that all ordered disciplines including therapy and social services will be started within the appropriate time frame and coordinated according to Policy and Procedure #2030 (coordination of services). All appropriate staff have been inserviced on this policy and are compliant as of January 6, 2008.	

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N 123	Continued From page 15 to the patient. On 12/2/08 at 1:23 PM, the Clinical Administrator confirmed the patient had not received an OT evaluation or treatment and the physician had not been notified of this. Further, he stated that the agency was having trouble providing OT services in outlying towns. The patient did not receive an OT evaluation and/or treatment per physician's orders. 2. Patient #7 was a 71-year-old female with a SOC date of 11/24/08, and was a current patient as of 12/02/08. She was admitted to the home health agency following left hip surgery on 11/11/08. The nursing assessment, dated 11/24/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, medications, meals, housekeeping and laundry. The patient's record contained a physician's order dated 11/19/08, requesting the agency to provide "Occupational Therapy." On 12/2/08, a second order, by a different physician was written for the patient to receive "Occupational Therapy for rehabilitation of hip replacement." As of 12/03/08, the patient had not received an OT evaluation and/or treatment. On 12/2/08 at 8:00 AM, the Clinical Administrator stated the physical therapist had assessed the patient on 11/24/08 and decided the patient would not benefit from OT services. He confirmed the patient had not received an OT evaluation or treatment and said the physician had not been notified of this. The patient did not received an OT evaluation and/or treatment per physicians' orders. 3. Patient #10 was a 90-year-old female with a SOC date of 9/23/08. She was discharged on 11/13/08. She was admitted to the home health agency due to being a high fall risk, increased fatigue, weakness, CVA, depression and	N 123		

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N 123	Continued From page 16 confusion. The nursing assessment dated 9/23/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, transferring, ambulation, medications, meals, housekeeping, and laundry. The patient's record contained a physician's order, that was not dated, requesting the agency to provide "Occupational Therapy." The record did not contain documentation that she had received an OT evaluation and/or OT treatment. On 12/2/08 at 3:57 PM, the Clinical Administrator reviewed the patient's record and confirmed there was not documentation that the patient had received an OT evaluation. He further could not find documented evidence that the physician had been notified of the above. The patient did not revive an OT evaluation and/or treatment per physician's orders.	N 123	N 152-	1/6/2009
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to develop, implement, and/or provide services consistent with the POCs for 2 of 3 private pay patients (#8 and #14) and 7 of 12 non-private pay patients (#1, #3 #4, #5, #7, #10, and #15) whose records were reviewed. This resulted in the inability of the agency to ensure care was provided in a systematic manner. The findings include:	N 152	The administrator will ensure that all patients referred to agency will be appropriately assessed and admitted to the agency according to policy and procedure #2008 (Attachment A). The administrator will also ensure that following the evaluation, a hand written Plan of Care will be sent to the physician for signature for orders of the home health disciplines in the interim time period that the 485/plan of care is being processed, audited, and data entried by the agency (This form can be found as attachment C). The administrator will also ensure that the physician will be notified of any missed	

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N 152	Continued From page 17 1. Patient #8 was a 14 year old male who was admitted following hospitalization for treatment of injuries received in a motor vehicle accident. These injuries included several fractures and internal injuries. His SOC was 10/31/08. As of 12/2/08, he did not have a comprehensive POC. The Clinical Administrator, interviewed on 12/2/08 at 11:30 AM, stated the patient was a private pay patient. The administrator said agency staff did not normally develop POCs for private pay patients. 2. Patient #14 was a 20-year-old male with a SOC date of 10/21/08. He was admitted to the home health agency following a hospitalization after he was involved in an accident. The patient's inpatient consultation, dated 10/12/08, documented the patient had injuries to his right lower extremity which included fractures as well as skin injuries. The nursing notes documented that, while receiving home health services, the patient was seen at a wound clinic for continued treatment of his skin grafts and had a wound-vac in place. The patient was a current patient as of 12/2/08. The patient's record did not include a POC. On 12/3/08 at 1:20 PM, the Clinical Administrator reviewed the patient's record. He confirmed a POC had not been developed and said it was not a normal practice to develop a POC for private pay patients. 3. Patient #3 was a 90-year-old female with a SOC date of 11/24/08, and was a current patient as of 12/02/08. She was admitted to the home health agency for monitoring and treatment of right foot cellulitis. The medical record contained an "Intake/Referral Form", dated 11/24/08 that documented the agency's nurse was to seen the patient 2 times a week. The patient resided in an	N 152	visits that are not following the Plan of Care (see attachment D). All appropriate staff have been inserviced on these policy and procedures and are compliant as of January 6, 2009.	

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N 152	Continued From page 18 RCF, and was also receiving PT services 2 times a week. Review of the patient's record documented that the agency had not developed a POC for Patient #3. Further, the record did not contain physician's orders for nursing and PT services. The record only contained an order written by a PA, dated 11/22/08, for a "Home Evaluation". This was confirmed by interview with the RN assigned to the patient, on 12/2/08 at 9:00 AM. The agency failed to develop and follow a POC. 4. Patient #4 was a 69 year old female with diagnoses of type II diabetes and chronic kidney disease. Her SOC was 11/19/08. Nursing notes documented she was being seen twice a day for insulin injections. As of 12/1/08, 12 days after the SOC, a POC had not been developed by agency staff. The Director of Home Care, interviewed on 12/1/08 at 3:15 PM, stated the POC had not been completed because staff had been too busy over the Thanksgiving holiday. 5. Patient #5 was an 88 year old female with diagnoses of joint pain and dementia. Her SOC was 9/24/08. Her new certification period started 11/23/08. Her POC was not completed until 12/1/08, 8 days after the certification period started. The Clinical Administrator, interviewed on 12/2/08 at 10:30 AM, stated the POC had not been completed until 12/1/08. 6. Patient #7 was a 71-year-old female with a SOC date of 11/24/08. She was a current patient as of 12/02/08. She was admitted to the home health agency following a left hip surgery on 11/11/08. The patient had a history of diabetes mellitus, pernicious anemia, hypertension, back surgery. She had been started on anticoagulation therapy after her surgery. The	N 152		

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N 152	Continued From page 19 physician ordered skilled nursing, OT and PT services on 11/19/08. The "Comprehensive Assessment", dated 11/24/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, medications, meals, housekeeping and laundry. The patient also had a surgical wound that needed monitoring. Review of the patient's record documented that the agency had not developed a POC for patient #7. On 12/3/08 at 10:30 AM, the Clinical Administrator stated the patient's POC had not been developed due to the holiday and the fact that the agency had admitted several of new patients during that past week. 7. The agency maintained a "PHYSICIAN LOG BOOK" for tracking documents sent to physicians. The log book tracked POCs sent between 10/3/08 and 12/1/08. The Office Manager maintained the the log. The log book documented 10 plans of care that were not developed until between 8 and 13 days after their SOC or certification dates. The Office Manager confirmed this during an interview on 12/2/08 at 10:00 AM. 8. Patient #1 was a 66-year-old female with a SOC date of 2/1/08. She was admitted to the home health agency following a hospitalization for a minimally displaced femoral neck fracture and underwent a right hip surgery. The patient was discharged from the agency's service on 3/6/08. The patient's POC, dated 2/1/08, stated the HHA would see the patient 1-2 times a week for six weeks. The patient was seen by the HHA on 2/8/08, and was not seen again by the HHA until 2/29/08. The patient did not receive HHA services during the 2nd, 3rd and the 4th week of service. The record did not contain documented evidence that the agency had notified the	N 152		

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N 152	Continued From page 20 physician of the missed visits. On 12/2/08 at 1:23 PM, the Clinical Administrator confirmed the missed visits. She stated the physician was not notified. She said it was not the agency's practice to notify physicians of patient missed visits. The agency provided fewer visits than what the physician had ordered and therefore, the agency altered the POC and should have notified the physician. 9. Patient #10 was a 90-year-old female with a SOC date of 9/23/08. She was discharged on 11/13/08. She was admitted to the home health agency due to being a high fall risk. The nursing assessment dated 9/23/08, stated the patient needed "assistance several times a day" with bathing, dressing, toileting, transferring, ambulation, medications, meals, housekeeping and laundry. The patient's POC dated 9/23/08, stated the HHA would see the patient once a week for six weeks. The patient was seen by the HHA on 9/27/08 and was not seen again by the HHA until 10/20/08. The patient did not receive HHA services during the 2nd, 3rd and the 4th week of service. Additionally, the HHA saw the patient on 11/10/08, during the 8th week of service. The agency did not have physician's order for aide services for week 8. The record did not contain documentation that the agency had notified the physician of the extra or missed visits. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed the physician was not informed of the extra or missed visits. The agency provided fewer and extra visits than what the physician had ordered and therefore, the agency altered the POC without notifying the physician. Further, the nursing assessment dated 9/23/08, stated the patient was depressed. The patient's record contained a physician's order, dated 9/23/08, requesting the agency to	N 152		

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N 152	Continued From page 21 provide a SW consult. The record did not contain documentation that the patient was provided a social worker's consult. On 12/2/08 at 3:57 PM, the Clinical Administrator confirmed the patient had not received an SW consult. 10. Patient #15 was an 80-year-old male with a SOC date of 10/15/08. He was a current patient as of 12/2/08. He was admitted to the home health agency due to increased confusion and weakness. The patient's POC, dated 10/16/08, stated the HHA would see the patient 2 to 3 times a week for six weeks starting on 10/19/08. The patient was seen by the HHA on 11/14/08 and was not seen again until 11/28/08. The patient did not receive HHA services during the 5th week of service. The record did not contain documentation that the agency had notified the physician of the missed visit. On 12/2/08 at 1:10 PM, the Clinical Administrator confirmed the physician was not informed of the missed visit. The agency provided fewer visits than the physician ordered, therefore the agency altered the POC and should have notified the physician.	N 152		